Name_____

Grade for **2026-2027**: 5th 6th 7th 8th 9th 10th 11th 12th

FREDERICA ACADEMY PARENTAL CONSENT FOR
PARTICIPATION IN ATHLETICS AND PHYSICAL EDUCATION COURSES

**WARNING:** Participation in interscholastic athletics and/or physical education courses at Frederica Academy includes risk of injury ranging in severity from minor to catastrophic, including permanent paralysis from the neck down or death. Although serious injuries are not common in supervised athletic activities, it is possible only to minimize, not eliminate, the risk. Participants have the responsibility to help reduce the chance of injury. Student-athletes must obey all safety rules, report all physical problems to their coaches/teachers, follow a proper conditioning program, and inspect their equipment/surroundings daily.

**CONSENT FOR PARTICIPATION:** By signing this consent form, you acknowledge that you have read and understand the above warning. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS CONSENT.

With full understanding of the risk involved, I/we release and hold harmless my child's school, it's employees, schools against which it competes, and contest officials of any and all responsibility and liability for injuries or claim resulting from such athletic participation. I/we agree to take no legal action against Frederica Academy because of any accident or mishap involving the athletic participation of my child.

I give consent for my student-athlete to:

(1) Participate in physical education courses offered through the school curriculum.
(2) Compete in athletics at Frederica academy, a member of the Georgia Independent School Association.
(3) Accompany any school team of which my child is a member on any of its local or out-of-town trips using transportation designated by the school/coaches.
(4) Have first aid and emergency medical treatment while under the supervision of Frederica Academy. In case of serious illness or injury, school personnel may call 911 for transport and emergency treatment at the nearest hospital.

This acknowledgement of risk and consent to participate shall remain in effect until revoked in writing.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

SIGNATURE OF
STUDENT_____DATE_____

**AUTHORIZATION FOR ON-CAMPUS PRE-PARTICIPATION PHYSICAL EVALUATION (PPE):** I certify that the medical history provided to Frederica Academy is complete and accurate. I understand that this medical screening is only to determine fitness eligibility for athletics/physical education courses and is not to take the place of regular physical examinations. I also understand that this evaluation will serve as the basis for determining that my child may compete in school athletics. I release and hold harmless the screening physician, screening staff, and Frederica Academy as it pertains to this athletic screening.

SIGNATURE OF PARENT/GUARDIAN_____DATE_____

**HEALTH INSURANCE INFORMATION:**

Health Insurance Company_____Phone number_____

Insurance Policy number_____Group number_____

**Southeast Georgia Health System Consent to Treatment and Waiver of Liability Form**

I _____ [Name of Parent or Guardian] am the parent or legal guardian of _____ [Name of Student]. I understand that Southeast Georgia Health System (the "Health System") provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of Frederica Academy, including pre-participation physical examinations. In case of emergency or accident on the school grounds or during any school activity involving the above-name student, which in the opinion of school authorities or personnel of the Health System present requires immediate medical or surgical attention, I hereby grant permission to such school authorities and Health System personnel to render medical treatment and to obtain the services of qualified medical personnel to treat the condition unless I am present and request otherwise or until I later request otherwise. I also authorize that a pre-participation physical examination be conducted on student.

I hereby release and agree to hold harmless Frederica Academy, the Health System, and their employees and agents, including, but not limited to, the Athletic Trainers and the Team Physicians or Team Physician Assistants, from any and all liability in case of accident, injury, damage or other mishap in connection with all medical services or athletic trainer services they provide to the above-named student.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Signature* | Telephone Number | Date |

**Authorization for Release of Medical Information**

I authorize the release of medical information to Frederica Academy by physicians and health care providers rendering services to Frederica Academy athletes. The purpose of the release of medical information is to allow Frederica Academy to determine the advisability of an athlete's participation in Frederica Academy athletics. An example would be the release of a screening physical examination. By agreeing to this release of medical information for my son, daughter or other person for whom I have the legal authority to act, I hereby authorize health care providers (including, but not limited to, the Health System and its physicians and athletic trainers) that are contracted with Federica Academy to release to each other and to Frederica Academy oral and written information relating to the athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of Frederica Academy. The medical information will be used by Frederica Academy for the purposes of determining the advisability of the athlete's participation in Frederica Academy athletics. **This authorization is expressly bound by the following conditions:**

- I understand that my protected health information is protected by federal law under Health Information Portability and Accountability Act (HIPAA) may not be disclosed without my authorization under HIPAA.

- I understand that my signing of this authorization/consent is voluntary and I am not required to sign this authorization/consent in order to be eligible for participation in Frederica Academy athletics.

- I understand that seeking treatment at practice, in training room or evaluation/treatment during games may be in the view of the general public. Frederica Academy and the Health System are in compliance with HIPAA regulations, maintain all medical documents and records in confidentiality, but the nature of treatment in these areas allows for other patients, students, athletes, and staff to be in use of these facilities during my treatment. By signing this document, I understand the possible implications and consent to treatment.

- This authorization will automatically expire upon the athlete's termination of participation in or ineligibility to participate in Frederica Academy athletics, except to the extent relied upon for disclosures made prior to the automatic expiration. I have the right to revoke this authorization in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

- I understand that there is a potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

- This authorization shall cover actions by and for Southeast Georgia Health System, Cooperative Healthcare Services, Inc. and all of their respective employees, workforce and business associates and all other physicians and healthcare providers contracted with Frederica Academy and their respective employees, workforce and business associates.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Signature* | Telephone Number | Date |

* This authorization must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the student's behalf. **By signing this form, you as the parent, guardian or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.** The signature may be only the athlete if the athlete is over 18 years of age.

# GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

# STUDENT / PARENT CONCUSSION AWARENESS FORM

**DANGERS OF CONCUSSION**

Concussions at all levels of sports have received a great deal of attention and a State Law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GIAA Athletics. One copy needs to be returned to the school, and one retained at home.

**COMMON SIGNS AND SYMPTOMS OF CONCUSSION**

- Headache, dizziness, poor balance, moves clumsily, reduced energy level / tiredness.
- Nausea or vomiting.
- Blurred vision, sensitivity to light and sounds.
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments.
- Unexplained changes in behavior and personality.
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**GIAA Concussion Policy**: If a Coach observes a Student-Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student-Athlete from practice, conditioning, or game. The Student-Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student-Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student-Athlete has suffered a concussion, the Student-Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student-Athlete return to practice, conditioning, or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out

***By signing this Concussion Awareness Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of concussions and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

**WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.**

SCHOOL NAME:_____

STUDENT'S NAME:_____STUDENT'S SIGNATURE:_____
(PRINTED)

PARENT'S NAME:_____PARENT'S SIGNATURE:_____
(PRINTED)

DATE SIGNED:_____

**GEORGIA INDEPENDENT ATHLETIC ASSOCIATION**

**STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM**

## LEARN THE EARLY WARNING SIGNS

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks, or ringing phones.
- Unusual chest pain or shortness of breath during exercise.
- Family members who had sudden, unexplained and unexpected death before age 50.
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome.
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks, or ringing phones.

## LEARN TO RECOGNIZE SUDDEN CARDIAC ARREST

If you see someone collapse, assume they have experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (seizure-like activity). Call for help and start CPR. You cannot hurt them.

## LEARN HANDS-ON CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it is easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED).
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

***By signing this Sudden Cardiac Arrest Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of sudden cardiac arrest and this signed Sudden Cardiac Arrest Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

**WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.**

SCHOOL NAME:_____

STUDENT'S NAME:_____STUDENT'S SIGNATURE:_____
(PRINTED)

PARENT'S NAME:_____PARENT'S SIGNATURE:_____
(PRINTED)

DATE SIGNED:_____

# GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

# HEAT POLICY AWARENESS FORM

**Definitions:**

A. **"Practice"** means the period of time that a student engages in coach-supervised, school-approved preparation for sport whether indoors or outdoors, including Acclimation Activities, conditioning, weight training, distance running, and scrimmages, but not including a Walk Through.

B. **"Walk Through"** means the period of time, not exceeding one hour per day, that a student engages in coach-supervised, school-approved sessions, whether indoors or outdoors, to work on formations, schemes, and techniques without physical contact. No protective equipment is worn during a Walk Through. No conditioning activities are held during a Walk Through. A Walk Through may not be held on a day when two practices are being held.

C. **"Acclimation Activities"** in football means practicing in shorts, shoulder pads, and helmets for five consecutive weekdays prior to practicing in full pads. No contact will be allowed during this period. Starting Date for Acclimation is July 25.

D. **"WBGT"** stands for the Wet Bulb Globe Temperature reading, which is a composite temperature used to estimate the effect of air temperature, humidity, and solar radiation on the human body, expressed in degrees. It is not equated with the "Heat Index."

**Policy:** All Member Schools will utilize at each Practice a scientifically approved instrument that measures WBGT. At the following WBGT readings the corresponding activity, hydration, and rest break guidelines apply:

**Under 82.0**
**Normal activities.** Provide at least three separate rest breaks each hour of a minimum duration of 3 minutes each during Practice.

**82.0 - 86.9**
**Use discretion for intense or prolonged exercise.** Watch at-risk students carefully. Provide at least three separate rest breaks each hour of a minimum of four-minute duration each during Practice.

**87.0 - 89.9**
**Maximum outdoor Practice time is two hours.** For football, students are restricted to helmets, shoulder pads, and shorts during Practice. All protective equipment must be removed for conditioning activities. For all sports, provide at least four separate rest breaks each hour of a minimum of four minutes each during Practice.

**90.0 - 92.0**
**Maximum outdoor Practice time is one hour.** No protective equipment may be worn during outdoor Practice and there may be no outdoor conditioning activities. There must be twenty minutes of rest breaks provided during the hour of outdoor Practice.

**Over 92**
**No outdoor activities or exercise.** Delay outdoor Practice until a lower WBGT reading occurs.

The following guidelines apply to **hydration and rest breaks**:

- Rest time should involve both unlimited hydrations (water or electrolyte drinks) and rest without any activity involved.
- For football, helmets should be removed during rest time.
- The site of the rest time should be a cooling zone not in direct sunlight, such as indoors, under a tent, or under a shade tree.
- When the WBGT is over 86, ice towels and spray bottles filled with ice water should be available in the cooling zone and cold immersion tubs will be available for a student showing signs of heat illness. A cold immersion tub may be anything, including a shower or wading pool that can be adapted to immerse a student in cold water and ice which is available within two-minutes travel from an outdoor Practice facility.

The following guidelines apply to **Practice**:

- All Member Schools must hold Acclimation Activities.
- No two-a-day Practices may exceed four hours for both sessions; no single Practice during two-a-days may exceed two hours. A three-hour rest period must be observed between the two sessions.
- No single Practice may last more than three hours.

Restrictions based on outdoor WBGT readings do not apply to indoor Practice where indoor air temperature is 85 degrees or less.

**Penalties**
Member Schools violating this policy will be fined a minimum of $500 and a maximum of $1,000 for the first offense. A Member School may be removed from membership for repeat violations.

***By signing this Heat Policy Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of heat and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

SCHOOL:_____

ATHLETIC DIRECTOR'S SIGNATURE:_____DATE:_____

STUDENT ATHLETE'S SIGNATURE:_____DATE:_____

PARENT'S SIGNATURE:_____DATE:_____

## PREPARTICIPATION PHYSICAL EVALUATION

# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of Examination: _____ Sport(s): _____

Sex at Time of Birth (Male or Female): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems?* ***(check box next to appropriate number)***

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Not being able to stop or control worrying | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Little interest or pleasure in doing things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling down, depressed, or hopeless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | ☐ | ☐ |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 3. Do you have any ongoing medical issues or recent illness? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | ☐ | ☐ |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | ☐ | ☐ |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | ☐ | ☐ |
| 7. Has a doctor ever told you that you have any heart problems? | ☐ | ☐ |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | ☐ | ☐ |

| HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*) | Yes | No |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | ☐ | ☐ |
| 10. Have you ever had a seizure? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | ☐ | ☐ |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | ☐ | ☐ |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | ☐ | ☐ |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | ☐ | ☐ |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | ☐ | ☐ |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | ☐ | ☐ |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | ☐ | ☐ |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | ☐ | ☐ |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | ☐ | ☐ |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 22. Have you ever become ill while exercising in the heat? | ☐ | ☐ |
| 23. Do you or does someone in your family have sickle cell trait or disease? | ☐ | ☐ |
| 24. Have you ever had or do you have any problems with your eyes or vision? | ☐ | ☐ |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | ☐ | ☐ |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | ☐ | ☐ |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | ☐ | ☐ |
| 28. Have you ever had an eating disorder? | ☐ | ☐ |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | ☐ | ☐ |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

**Explain "Yes" answers here.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

## PREPARTICIPATION PHYSICAL EVALUATION

# PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

### *PHYSICIAN REMINDERS*

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | ☐ | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | ☐ | |
| Lymph nodes | ☐ | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | ☐ | |
| Lungs | ☐ | |
| Abdomen | ☐ | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis | ☐ | |
| Neurological | ☐ | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | ☐ | |
| Back | ☐ | |
| Shoulder and arm | ☐ | |
| Elbow and forearm | ☐ | |
| Wrist, hand, and fingers | ☐ | |
| Hip and thigh | ☐ | |
| Knee | ☐ | |
| Leg and ankle | ☐ | |
| Foot and toes | ☐ | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | ☐ | |

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____